In Defense of the Obstetrician and Obstetrics

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■ *Changes and advances in obstetrics are emphasized by the comparative study of private and one hospital practice in 1939 and 1964. Education, prenatal care, anesthesia, antibiotics, transfusions have all been instrumental. Old problems—abortion, toxemia, prematurity, developmental abnormalities—remain with us. New developments, both professional and economic, some not desirable, face us and demand that active practicing obstetricians take an active role in helping direct their course.*

IT IS WELL to remember that obstetrics as we know it has a rather short history. The first obstetrical lectures I attended, in 1930, were presented by Dr. Reuben Peterson, a pioneer obstetrician at the University of Michigan. To recall the names of a few of those active in teaching at that time is to recite a list of giants among the founders of our profession: Williams, De Lee, Polak, Jeff Miller, Beck and San Francisco's own Frank Lynch. The bases of our specialty laid by such men as these have been firm foundations on which others have built our rapidly developing and changing practice.

To review these changes points up the differences between our former procedures and today's, and at the same time calls attention to the accelerating accumulation of knowledge and its effect on our thinking. Such a review also indicates where we are heading. To make these comparisons more specific, I have chosen to compare some present-day facts with those in a study I presented before the staff of San Diego's Mercy Hospital in 1940.

Gross maternal mortality rates portray most dramatically one change in obstetrics. The rate had been above 60 per 10,000 live births until the early 1930's. In 1938 it was 43.5. The rate in 1963 (the latest year for which data were available) was 3.7. In San Diego County, it was 29.0 in 1939, 3.5 in 1963. At Mercy Hospital it was 15.0 in 1939, 3.4 in 1964.

Neonatal mortality rates also depict great improvement. The national rate was 29.3 per 1,000 live births in 1939. In San Diego County it was 34.2 per 1,000; at Mercy Hospital 19.0. In 1963, the national rate was 18.5 per 1,000; at Mercy Hospital 16.2.

Obstetricians cannot take credit for all of this improvement. The great contributions by research personnel, the improvements in anesthesia, the development of sulfa drugs and antibiotics, the universal availability of blood and the great efforts by pediatricians have all combined to help. However, much of the credit must go to obstetricians. The improvement in training, both in the specialty of obstetrics and in improved facilities for training general practitioners; the increase in numbers of deliveries in hospital, and the great increase in scope of prenatal care, have all been major factors. Obstetrics has changed from midwifery or, as it once was, a subspecialty of surgery, into an honored and respected specialty in its own right.

That we still have problems, all must admit. It may be valuable to review some of these briefly.

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It may come as a surprise to realize that some of our most important problems are still the same old ones we have had all along. In the splurge of writings about some of the newer and more glamorous conditions and procedures, these old enemies may be overlooked, even though they are the frequent, common and more important. In obstetrics, as in all medicine, the new and exciting things take first attention, but then fade as time and thought gives a more accurate assay of importance, and sink back to their rightful smaller place. The old seem ever with us.

Abortion remains one such enigma, for after all the suggested ritualistic procedures, gallons of orange juice, pounds of progesterone, administered however hopefully, we must admit that at least statistically we have made almost no progress in preventing abortion very early in pregnancy. The increased understanding of the problem with the knowledge that most abortions result from abnormal development, perhaps on a genetic basis, is helpful only in that it allows us to explain to our patients our failure to prevent its occurrence. The same holds true of prematurity. We still do not know how to prevent most premature births. So far, we cannot stop labor.

During the last 25 years the reasons for some fetal deformities have become evident. Those found following rubella are well known, and we all await anxiously the vaccine to prevent that disease, for we must admit that all other means, including gamma globulin, have been of little value. Fortunately deformities following other diseases, such as mumps and toxoplasmosis, are rare. These causes were unknown 25 years ago, just as deformities following drug administration were unknown. It is tragic that a great catastrophe such as the recent one associated with thalidomide must occur before this sort of thing comes to light. But then, all knowledge comes hard.

The cause of erythroblastosis was unknown 25 years ago. Despite discovery of RH factor, all efforts at control failed, and one could adopt an almost nihilistic attitude, until Liley came along with amniocentesis and intrauterine transfusion, which offers some hope for a few of the unfortunate. This is no ultimate answer, but it is a start.

Toxemia remains a major threat, although by virtue of the research of such men as our own Nick Assali we have made great strides, at least in controlling symptoms. The newer drugs have resulted in a decrease in serious complications, but we still have much to learn about the cause, nature and cure of the condition. Prenatal care has proved its value in prevention.

Some diseases which can still be serious when encountered during pregnancy—tuberculosis and rheumatic heart disease, for example—become relatively less important, owing to general advances in medicine. The increased number of live babies born to diabetic mothers is also an example of improved general medicine, and especially of teamwork between obstetrician and internist. This happy result could have hardly been imagined 25 years ago.

Almost all of us admit the value of prenatal care. But even this is changing. One change is a shift to group or mass education of patients, taking some of the good points from the "natural childbirth" idea, which helps patients to greater understanding and cooperation. This is a shift away from the great emotional dependence on the obstetrician which many patients developed in the past. At the moment, this seems to be good. However, time alone will place these efforts in their proper place. The great flurry over total "natural childbirth" has now so subsided that about its only vociferous advocates are a small pseudointellectual cult with almost religious fervor for it. That there are good points is not denied; these we have adopted. The great use of this procedure in Russia is often held up to us by enthusiasts, but we become somewhat disillusioned when travelers report that the best estimate is that only 60,000 women in the "institutes" devoted to this type of delivery use it, out of the more than 4,000,000 women who have babies each year.

The changes in procedures directly related to delivery are most pronounced. One of the most evident relates to medication during labor. Whereas 25 years ago women were "knocked out" by large doses of barbiturates, scopolamine, and perhaps rectal paraldehyde, we now use as little medication as we can, hoping that better instruction of the mother beforehand will make it possible to use smaller doses and result in better babies. Although there seemed to be little evidence of serious damage to newborns in older times, who can forget the sleepy babies and the odor of paraldehyde in the nursery.

Those of us who use spinal-saddle block or caudal anesthesia are convinced of its safety as compared with general anesthesia induced by gas or ether, and in the unusual event that general an-

esthesia must be used, we are impressed at how differently the babies react. It is dismaying, therefore, to find that in many institutions in the United States, general anesthetic agents are still the major ones used. Often this is because these hospitals, unlike most of ours in California, do not have physicians specializing in anesthesiology to administer obstetrical anesthesia.

Whereas 25 years ago there were many papers presented on the pros and cons of induction of labor, no one today denies its usefulness if judiciously employed. Even so, continuing physician education on induced labor is needed.

At Mercy Hospital in 1939 only 35.5 per cent of patients had low forceps delivery; in 1964 the proportion was 63 per cent. Midforceps delivery was used in 1.78 per cent of cases in 1939; in only 1.4 per cent in 1964. There was one high forceps delivery in 1939, none in 1964. In 1939, 2.5 per cent of births were by caesarean section; the rate was 6.7 per cent in 1964, and 50 per cent of these operations were on women who had previously had at least one extravaginal delivery, compared with only 21 per cent in 1939.

While few of us believe that caesarean section can be considered a stand-by way out of trouble, the increased rate reflects the thinking that a more liberal use of caesarean section actually is conservative obstetrics. The decrease in obvious damage to mother and baby seen after more heroic methods in times past justifies this position.

Methods of handling the third stage of labor certainly are an improvement. The knowledge that when the placenta does not readily deliver it can be safely removed by hand has often prevented loss of blood and avoided the hazards of the transfusions that otherwise would be needed. We do not advocate the routine manual removal as a clinical procedure, but we do strongly recommend exploration of the uterus after delivery of the placenta to be sure that there are no retained secundines and no lacerations which should be repaired.

Early ambulation postpartum is now universally accepted. The difference between our present procedure and the eight or nine days of bed rest that we used to think advisable is very evident. We are now less often plagued by embolism as a late sequel. My own early experience with natural childbirth and early ambulation came when I delivered a Navajo Indian woman under a tree beside a wagon during the Pow Wow at Flagstaff, Arizona, in 1936. When I went back to see how she was the next morning, the woman, the baby and the wagon had all gone on their way. This is primitive learning.

In 1939 three of a total of 1,956 women delivered at Mercy Hospital died, one from bronchopneumonia, one from puerperal sepsis of the old standard type, and one from puerperal sepsis after caesarean section that had not been done until long after rupture of membranes. In 2,887 deliveries in 1964, one woman died, of "gram-negative shock." It seems true generally that there is not only a decrease in maternal mortality but a change in type of mortality. In some series deaths have been due to non-obstetrical causes—poliomyelitis and subarachnoid hemorrhage, for example—and even those from obstetric causes are often from different types of infection, such as the septic shock variety. Mortality rates have become so low that extreme vigilance is necessary to improve them.

Eighty-three per cent of the deliveries at Mercy Hospital in 1964 were performed by specialists in obstetrics. This is a different situation from that in many hospitals. It is variously estimated that in the United States somewhere between 60 per cent and 70 per cent of pregnant women are under the care of general practitioners. Good obstetrics practiced by trained obstetricians results in good care. The efforts to improve the education of the generalist has also paid off in handsome improvements. This education is a project all obstetricians should engage in, for raising the general level of knowledge in obstetrics will provide better and better care for more and more women.

Fertility

One of the new functions thrust upon obstetricians is a part in population control. This includes studying and treating infertility. This seems a paradox in times when so many people are worried about the population explosion, but it is true everywhere that infertile women want children. With more reasonable methods of study and new agents to help with ovulation, our results improve, albeit slowly. Further success will come only with better understanding of the processes of human reproduction.

Contraception

When I was a senior in medical school at Michigan in 1932, Dr. Norman Miller presented to us

behind locked doors the first lecture on contraception given to a medical school class at that institution. How far contraception has come can be realized now that there is talk of governments supplying information to whole countries. The problems attendant on world population explosion almost force mankind to do something about it. For the first time we have really effective methods of contraception, which while not foolproof, and still somewhat expensive for mass use, are simple, effective and practical. Most of us are called upon by patients for information on this subject, and I believe it is our duty, within the limits of our own religious and ethical beliefs, to supply it. I believe that many of those who speak so alarmingly about the expected growth in population and many of those who believe that most women want as many babies as possible, are in error. In light of the fact that more than four and a half million women in the United States are using oral contraceptives, the present drop in birth rate must be owing at least in part to a wish to limit family size. This field requires very careful study on the part of all of us to be sure that we do not do women damage from prolonged use of any of the new methods, tablets by mouth, intrauterine devices, or what not.

That a growing population may place great demands on obstetricians and general physicians to provide good care cannot be denied. One way that we can help in this situation is to interest promising young men in obstetrics as a profession. We should make every effort to enlist those who show interest in medicine and especially in obstetrics. Certainly no specialty offers more personal satisfaction, and we should be proud to make our position known.

We are facing threats of further inroads by paramedical personnel into fields traditionally ours. And now some of our own are suggesting further that delivery of "those not expected to have complications" be turned over to midwives. Various sorts of substitutes are suggested, from nurses given additional training, to people about half trained as physicians. I believe that these suggestions pose great danger to American women. There are many paradoxes present. At a time when great emphasis is being placed on the emotional support of pregnant and parturient women, someone suggests taking away from the women the one person on whom she depends for the greatest support, the obstetrician, and replacing him with a somewhat impersonal poorly trained interloper. American women desire private, personal care. In our local community, when the original Medicare program—when the word was used for the care of servicemen's dependents—allowed the women free choice between the available military clinic services or private physicians, 75 per cent of the women chose private care, despite the fact that the clinic care is the best that can ever be expected in mass medicine. These patients were easily absorbed by local physicians and hospital facilities. This suggests that instead of building expensive vast clinic facilities, the government might better subsidize indigent patients and use existing personnel and private hospitals for their care.

The idea of turning over for delivery "those not expected to have complications" perplexes me, for I doubt that any of us is good enough at determining which women will not develop complications at delivery—sometimes precipitously and to catastrophe. Partly trained personnel, called by whatever name, can be helpful in much of the work having to do with obstetrical practice—in prenatal clinic work, for example, or perhaps in making follow-up house calls on patients who do not show up for clinic appointments. However, to delegate to such people medical technical functions, often dependent on good medical judgment, seems to me to be a backward step. A patient's neglect of attending prenatal clinics is largely a reflection of failure of patient education, and can be corrected only by mass community efforts to convince patients that what may seem to them needless bother, is very much in the interest of their own welfare.

Patients and the community we must educate, but first and continuously ourselves. There will be changes in the tools of medicine, in our methods of practice, and perhaps even in the economics of medical care, but through them all we must never lose sight of our goal of happy, healthier mothers with healthy babies. As practicing obstetricians who understand our patients as well as we understand our goals, let us play the biggest part in determining the direction these changes take.

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